

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12308

CERTIFICATE OF DEATH

12286

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 months 4 d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 6138 Marlboro Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Josephine Lucchesi		First	Middle	Last	4. DATE OF DEATH 12	Month	Day	Year 8 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-05	9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? unkn		
13. FATHER'S NAME Camillo Lucchesi		14. MOTHER'S MAIDEN NAME Patrina Scopello		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. unkn		17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 72 hours		
443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Hypertensive cardiovascular disease				years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Invol. psych. react. CBS assoc. with cerebr. arterioscl. with psych. react.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Baltimore		(State)
21. I certify that I attended the deceased from 10-4-56 , 19 56 , to 12-7- , 19 56 , that I last saw the deceased alive on 12-7- 1956 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edmund Lusthaus M.D. Springfield State Hospital 12-8-56								
ACTUAL SIGNATURE Edmund Lusthaus								
PHYSICIAN'S NAME (Type) Edmund Lusthaus		Sykesville, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORIY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS		24a. REC'D BY REGISTRAR 12-8-56		24b. REGISTRAR'S SIGNATURE C. Harry Teller		

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12309

CERTIFICATE OF DEATH

12287

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>15 Westminster Ave</i>		d. STREET ADDRESS <i>15 Westminster Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Robert</i>	Middle <i>Brilhart</i>	Last <i>Dec 27</i>
4. DATE OF DEATH <i>Dec 27</i>	Month <i>Dec</i>	Day <i>27</i>	Year <i>1956</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wh</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/29/1883</i>
9. AGE (In years last birthday) yrs. <i>73</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Charles Brilhart</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Frankforter</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>212-32-1395</i>	17. INFORMANT Address <i>Mrs Eddie C Brilhart, Manchester</i>	18. CITIZEN OF WHAT COUNTRY? <i>USA</i>
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>381X</i>		DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c)	
5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>Manchester</i>		(County) <i>Md</i>	
		(State) <i>Md</i>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>48</u> to <u>Dec 27</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>56</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>23 North Main St</i>			
DATE SIGNED <i>12/27/56</i>			
ACTUAL SIGNATURE <i>W. H. Board</i>			
PHYSICIAN'S NAME (Type) <i>Manchester, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/30/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Manchester</i>	22d. LOCATION (City, town, or county) <i>Manchester</i>
		(State) <i>Md</i>	
23. FUNERAL-DIRECTOR'S SIGNATURE <i>Frederick Bucker & Son Inc.</i>			
ADDRESS <i>15 Westminster Ave</i>			
24a. REC'D BY REGISTRAR DATE <i>19-56 Mrs. H. S. Donner</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1554

BUREAU V. S.
REGEIV EO
DEC 31 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12310

CERTIFICATE OF DEATH

12288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 years, 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 16	
3. NAME OF DECEASED (Type or print) Cora Elizabeth Stephens BROENING		First	Middle
		Lost	4. DATE OF DEATH December
		Month	Day
		Year	5, 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH July 5, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (In years last birthday) 75 yrs.
		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles W. Stephens		14. MOTHER'S MAIDEN NAME Emma Walraven	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Springfield Hospital records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH years	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Lobar Pneumonia DUE TO (c)		2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis due to disturbance of circulation, cardio-renal disease and cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town)	(County)
		(State)	
21. I certify that I attended the deceased from November 21, 1951, to December 5, 1956, that I last saw the deceased alive on December 5, 1956, and that death occurred at 5:10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.		DATE SIGNED 12/5/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/56	22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Cem.	22d. LOCATION (City, town, or county) Wobblawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schaefer & Sons - Baile, 17th	ADDRESS	24a. REC'D BY REGISTRAR DATE Dec. 10, 1956	24b. REGISTRAR'S SIGNATURE C. Harry Steers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
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CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
DECEMBER 11 1956				
FBI - BALTIMORE				
BUREAU V. S.				
RECEIVED				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12311

CERTIFICATE OF DEATH

12289

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b <i>life</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Carroll</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Paul Franklin Brown</i>		First	Middle	Last	4. DATE OF DEATH <i>Dec. 26 1956</i>	Month	Day	Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-20-1909</i>	9. AGE (In years lost birthday) <i>47 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>0</i>	11. IF UNDER 24 HRS. <input type="checkbox"/> Days <i>0</i>	12. IF UNDER 24 HRS. <input type="checkbox"/> Hours <i>0</i>	13. IF UNDER 24 HRS. <input type="checkbox"/> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>cinematographer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gas & Elec Co</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Frank W. Brown</i>		14. MOTHER'S MAIDEN NAME <i>Mary H. Lonsdale</i>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <i>21 yrs in Navy</i>		16. SOCIAL SECURITY NO. <i>217-28-1236</i>		17. INFORMANT <i>Mr. Effie Brown - Sykesville, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>cerebral hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr -</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hypertensive cardio-vascular disease</i> DUE TO <i>3 yrs -</i>									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Sykesville</i>		(County) <i>Carroll</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>1947</i> , 19 <i>47</i> , to <i>26 December 1956</i> , that I last saw the deceased alive on <i>26 December 1956</i> , and that death occurred at <i>5:20 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Liberty Road at Eldersburg</i>		DATE SIGNED			
ACTUAL SIGNATURE <i>W.H. Lawson</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>W.H. Lawson, Jr. M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-28-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Sykesville, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Effie A. Haigle - Sykesville, Md.</i>		ADDRESS <i>Sykesville, P.O., Maryland</i>		24a. REC'D BY REGISTRAR <i>C. Henry Sweet</i>		24b. REGISTRAR'S SIGNATURE <i>C. Henry Sweet</i>			
DATE <i>12-27-56</i>									

DEPARTMENT OF DEFENSE - BALTIMORE 21231

BUREAU V. S.

JAN 3 1957

REGELIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12290

12312

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. 4 WESTMINSTER		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. 4 WESTMINSTER	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josiah		First W	Middle CLICK
4. DATE OF DEATH Month DEC.		Month 26	Day Year 1956
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3-1872	
9. AGE (In years lost birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER RET		10b. KIND OF BUSINESS OR INDUSTRY M.D.	
11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILLIP CLICK		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT MRS. JAMES MURDOCK		Address R.D. 4 WESTMINSTER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 442x PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>My second b'm (dn) Hepatitis (ch)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1946, to Dec 26 , 1956, that I last saw the deceased alive on Dec 26 , 1956, and that death occurred at 3:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.C. Jeannette		ADDRESS (Street, city or town, state) Westminster, MD. 12-22-56	
PHYSICIAN'S NAME (Type) W.C. Jeannette MD		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-29-56	
22c. NAME OF CEMETERY OR CREMATORIAL LEISERS CEM.		22d. LOCATION (City, town, or county) WESTMINSTER, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard		ADDRESS Westminster, MD.	24a. REC'D BY REGISTRAR Harriet Miller
23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard		ADDRESS Westminster, MD.	24b. REGISTRAR'S SIGNATURE Harriet Miller

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
31 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12313

CERTIFICATE OF DEATH

12291 74
Reg. Dist. No. ✓

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 7mos. 23days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
3. NAME OF DECEASED (Type or print) Susan		First Lucinda	Middle COOL
4. DATE OF DEATH December 20		Month Month	Day Day
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 27, 1890.		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. ADDRESS Springfield Hospital records.	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia		INTERVAL BETWEEN ONSET AND DEATH Weeks	
260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Decubitus ulcer		Months	
DUE TO (c)			
C. B. S. assoc. with circ. disturbance with cerebral arteriosclerosis, with psychotic reaction, plus diabetes.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 20, 1954 , to Dec. 20, 1956 , that I last saw the deceased alive on Dec. 20, 1956 , and that death occurred at 10:35 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Edmund Lusthaus, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		DATE SIGNED 12/21/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/56	
22c. NAME OF CEMETERY OR CREMATORIAL St. Andrews		22d. LOCATION (City, town, or county) (State) Waynesboro Franklin Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Ulloa		ADDRESS Waynesboro Pa.	
		24a. REC'D BY REGISTRAR DATE DEC 26 1956	
		24b. REGISTRAR'S SIGNATURE Harry Hens	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8: ДРОНТАВ—ИЗДАНИЕ ТВОРЧЕСКОГО СОУЧЕСТВИЯ ОДНОИМЯННИКА

BUREAU V.

DEC 26 1956

RECEIVE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12292
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 26

12305

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Westminster

c. LENGTH OF STAY IN 1b

Few Hours

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Main & Green Sts.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE Maryland

b. COUNTY Baltimore City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

3401-4

d. STREET ADDRESS

3108 Bayonne Avenue

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First Albert Gordon Middle Cootes Last

4. DATE
OF
DEATH
12 24 1956
Month Day Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

June 19, 1906

9. AGE (in years
at birthday)
50 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Barber

10b. KIND OF BUSINESS OR INDUSTRY

Barber Shop

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Charles E. Cootes

14. MOTHER'S MAIDEN NAME

Emma J. Chrest

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
no

16. SOCIAL SECURITY NO.

212-28-5651

17. INFORMANT

C. Edward Cootes

Address

Westminster, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

330 X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)
DUE TO
(c)

Subarachnoid Hemorrhage

Aspiration of Vomitus

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

William V. Lovett

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12-25-56

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF
12-27-56

22c. NAME OF CEMETERY OR CREMATORIUM
Westminster

22d. LOCATION (City, town, or county)
Westminster

(State)

Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John R. Byers Westminster, Md.

24a. REC'D BY REGISTRAR

DATE 12-26-56

24b. REGISTRAR'S SIGNATURE

Harriet Miller

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

WATERBURY STATE EXAMINER'S CERTIFICATE OF DEATH

U. S. BUREAU

DEC 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12293

Reg. Dist. No.

74

12314

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		12314 Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 18		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Springfield State Hospital		d. STREET ADDRESS		639 E. 29th Street		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Annie Elizabeth Mitchell CROFOOT					December 6			1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 21, 1891	65 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
None			None	Maryland		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Timothy Mitchell				Anne Mann				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No				Springfield Hospital records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary thrombosis, both lungs</u> INTERVAL BETWEEN ONSET AND DEATH hours								
422.1 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <u>Arteriosclerotic cardiovascular disease</u> years								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
Involutional psychotic reaction								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
James T. Marsh, M.D.		DATE SIGNED 12/6/56						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10/56		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.		22d. LOCATION (City, town, or county) Balto. Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Withey,		ADDRESS 4101 Edmondson		24a. REC'D BY REGISTRAR DEC 10 1956		24b. REGISTRAR'S SIGNATURE C. Harry H. Withey		

DEC 10 1968

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12294

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12315

1. PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville

c. LENGTH OF STAY IN 1b

lyr. 25 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Balto. City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore City

38014

d. STREET ADDRESS

3320 Fait Ave., Balto. 24, Md.

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First
Hnat

Middle

Last
DEMIANCHIK

4. DATE
OF
DEATH

Month
December

Day
21

Year
1956

S. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

January 2, 1876

9. AGE (In years
last birthday)

80

yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

unknown RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

FARMER.

11. BIRTHPLACE (State or foreign country)

Austria

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown PETER DEMIANCHIK

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Springfield Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Embolism

INTERVAL BETWEEN
ONSET AND DEATH

Hours

34

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Cerebral Arteriosclerosis

Years

DUE TO

(c)

Generalized arteriosclerosis

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
C.B.S. asso. with circ. dist. with cerebral arteriosclerosis with psychotic
reaction. - Thrombosis, right kidney.

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell to floor of ward.

20c. TIME OF INJURY
Month, Day, Year
Hour 2:00
p. m.

12/20/56

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Hospital

20f. (City or town)

(County)

(State)

Sykesville

Carroll

Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that
death resulted from: Nutrol causes Accident Suicide Homicide Undetermined cause

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type) James T. Marsh, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

12/21/56

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

12-24-56

22c. NAME OF CEMETERY OR CREMATORIUM

ST. STANISLAUS CEM.

22d. LOCATION (City, town, or county)

1300 DUNDALK Ave., BALTO., MD.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles J. Geiler

ADDRESS

901 S. CONKLING ST.

BALTO., MD.

24a. REC'D BY REGISTRAR

DEC 26 1956

DATE

24b. REGISTRAR'S SIGNATURE

C Harry Hays

DEPARTMENT OF HOMELAND SECURITY
WEDGWOOD DOCUMENTS CERTIFICATE OF DEATH

RECEIVED
BUREAU U.S.
DEC 27 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12316

CERTIFICATE OF DEATH

12295

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Mt. Airy	
3. NAME OF DECEASED (Type or print) MARY		4. DATE OF DEATH Month Day Year December 26 1956	
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 1, ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Asbury Favington		14. MOTHER'S MAIDEN NAME Angeline Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hildrea Dorsey, Mt. Airy, Md,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 6 years	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized Arteriosclerosis		Several years.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1950</u> , to <u>December, 1956</u> , that I last saw the deceased alive on <u>December 13, 1956</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Culwell		ADDRESS (Street, city or town, state) Se. Main St. DATE SIGNED 12/27/56	
PHYSICIAN'S NAME (Type) W.B. Culwell		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-29-1956	
22c. NAME OF CEMETERY OR CREMATORIAL Fairview		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE DEC 28 1956		24b. REGISTRAR'S SIGNATURE Elma Hewitt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK - ATTORNEY GENERAL
CERTIFICATE OF DEATH

NAME

AGE

CAUSE

BUREAU V. S.

DEC 9 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12317

CERTIFICATE OF DEATH

12296

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 29yrs. 6mos. 5days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. V.O. 1-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Margaret		Middle DUVALL		4. DATE OF DEATH December 12, 1956		Month December	Day 12	Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown		9. AGE (In years lost/birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Unknown			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Springfield Hospital records.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas INTERVAL BETWEEN ONSET AND DEATH Months 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 092X (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dementia praecox, paranoid type; Pulmonary tuberculosis; fracture, left arm. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell on the ward.							
20c. TIME OF INJURY Hour o. m. 11:15 a.m.		Month, Day, Year 11/21 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital		20f. (City or town) Sykesville	(County) Carroll	(State) Md.
21. I certify that I attended the deceased from July 1, 1950 , to December 12, 1956 , that I last saw the deceased alive on December 12, 1956 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Walther H. Sonnenfeldt, M.D. Springfield State Hospital DATE SIGNED 12/12/56									
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.		22. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-56	22c. NAME OF CEMETERY OR CREMATORIAL New Baltimore		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Fuller Wright		ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 12-12-56		24b. REGISTRAR'S SIGNATURE C. Harry West			

ST 390M124-371A39 RC THURSDAY 25 SEP 2012 09:47:54AM

BUREAU Y. S.

DEC 17 1956

REFUGEE ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

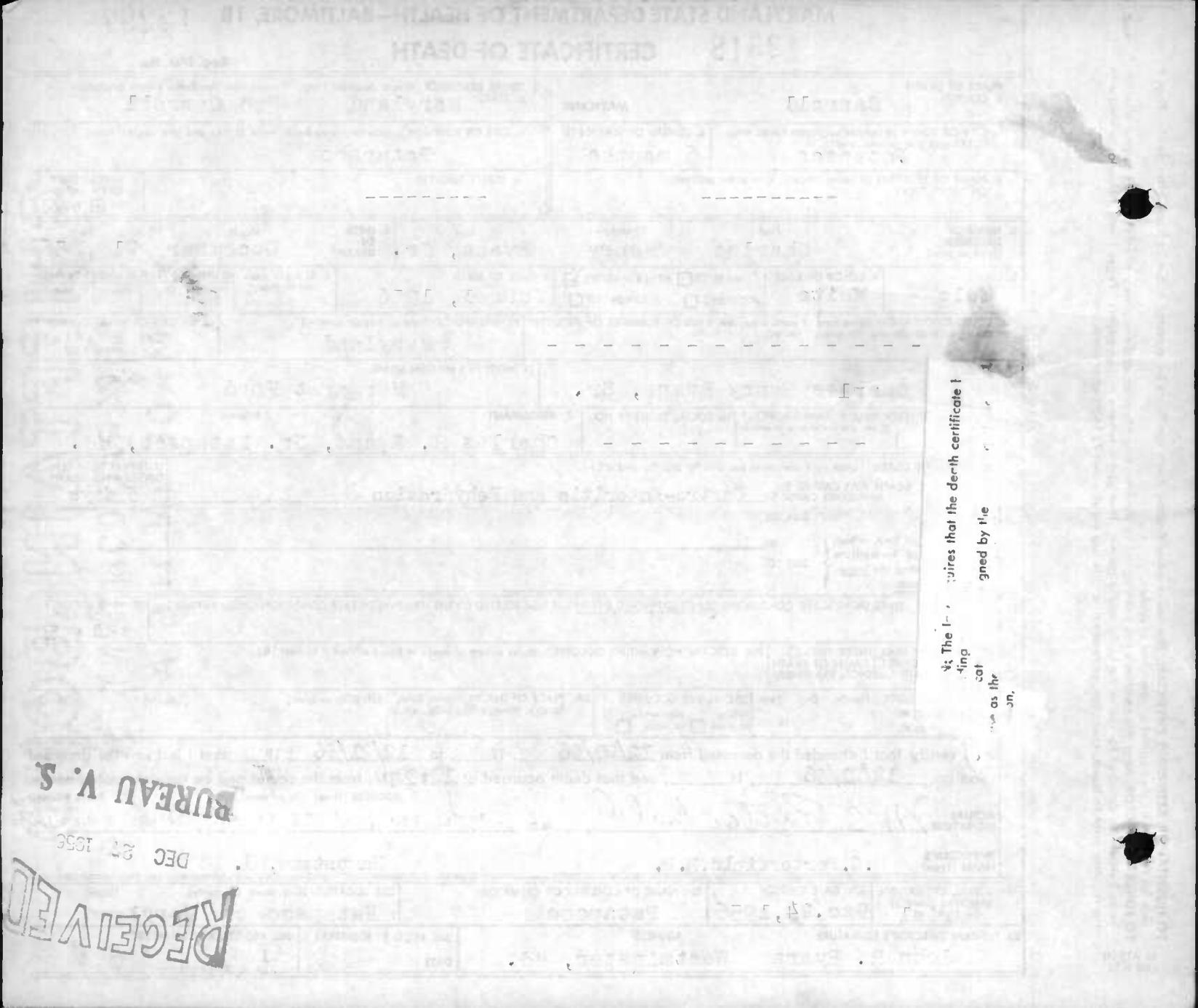
12297

12318

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Henry	Last Evans, Jr.
4. DATE OF DEATH	Month December	Day 21	Year 1956
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1956
9. AGE (In years lost birthday) yrs. 6	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Henry Evans, Sr.		14. MOTHER'S MAIDEN NAME Margaret Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT no		Address Charles H. Evans, Sr. Patapsco, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Enteritis and Dehydration			
571.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/20/56 , 19, to 12/21/56 , 19, that I last saw the deceased alive on 12/21/56 , 19, and that death occurred at 10:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. C. Porterfield</i>		ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 12/21/56	
PHYSICIAN'S NAME (Type) M. C. Porterfield, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Dec. 24, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Patapsco	
22d. LOCATION (City, town, or county) Patapsco		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR DATE 12-24-56		24b. REGISTRAR'S SIGNATURE Harriet Muller	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12332

12351

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b 3 mo, 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Alice	Middle Virginia	Fringer Sherrer	Lost SLADE	4. DATE OF DEATH December 6,	Month 19	Day 56	Year
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 23, 1880	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. HRS. Hours	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas mill worker	10b. KIND OF BUSINESS OR INDUSTRY Homemaker	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Martin Sherrer	14. MOTHER'S MAIDEN NAME Cecilia Hopkins
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Springfield Hospital records	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Coronary occlusion	INTERVAL BETWEEN ONSET AND DEATH hours
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Far advanced pulmonary tuberculosis	years
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20g. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from alive on and that death occurred at	August 31, 1956	to December 6, 1956	that I last saw the deceased
			ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE Edmund Lusthaus	DATE SIGNED 12/6/56		

PHYSICIAN'S NAME (Type)	Edmund LUSTHAUS, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-9-56	22c. NAME OF CEMETERY OR CREMATORIUM Clysmalera Meth.	22d. LOCATION (City, town, or county) Monkton, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks	ADDRESS Towson, Md.	24a. REC'D BY REGISTRAR DATE Dec. 10 1956	24b. REGISTRAR'S SIGNATURE Harry Hens

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12319

CERTIFICATE OF DEATH

12298 74

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

CARROLL

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SYKESVILLE

c. LENGTH OF STAY IN 1b

3 WEEKS

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

PULLEN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

MARYLAND

b. COUNTY

CARROLL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RURAL WOODBINE, R.D.1

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

MANNIE

First MIDDLE

Last FLEMING

4. DATE
OF
DEATH

Month DECEMBER

Day 16 Year 1956

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

8 / 20 / 1882

9. AGE (In years
lost birthday)

74 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

CARROLL CO. MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

THOMAS J. GUNN

14. MOTHER'S MAIDEN NAME

NAINIE E. ZEBOKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-24-2821

17. INFORMANT

THOMAS EDWARD FLEMING R.D.1 WOODBINE, MD

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

332X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Cardiac Arrest, Arteriosclerosis generalized,

Cerebral Thrombosis, left hemiplegia,

Bronchial pneumonia.

INTERVAL BETWEEN
ONSET AND DEATH

June 5b

to

Dec 5b

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
White Not white
of work of work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that I attended the deceased from April 1954, to Dec 1956, that I last saw the deceased
alive on April 1954, and that death occurred at 9 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Howard E. Hall M.D.

PHYSICIAN'S
NAME (Type)

HOWARD E. HALL

SYKESVILLE, MARYLAND

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

12/ 9/ 1956

22c. NAME OF CEMETERY OR CREMATORI

MORGAN CHAPEL CEMETERY

22d. LOCATION (City, town, or county)

(State)

CARROLL CO. MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE

C. M. WALTZ

ADDRESS

WINFIELD, MD.

24a. REC'D BY REGISTRAR

DE 10 1956

24b. REGISTRAR'S SIGNATURE

C. Harry Heers

BUREAU U. S.

DEC 30 1956

RECEIVED
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12320

CERTIFICATE OF DEATH

12299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 7 yrs, 1 mo, 12 dyes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		d. STREET ADDRESS Lodge Forrest Dr. & North Point Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Minnie	Middle Price	Last Forbes
4. DATE OF DEATH	Month December	Day 7	Year 19 56
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 3, 1917
8. AGE (In years last birthday) 39 yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	11. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Kentucky		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Price		14. MOTHER'S MAIDEN NAME Cilly Heard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT No		Address Springfield Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the cervix</u>		INTERVAL BETWEEN ONSET AND DEATH 1 year plus	
19. MEDICAL CERTIFICATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21. I certify that I attended the deceased from <u>July 1, 1950</u> , to <u>December 7, 1956</u> , that I last saw the deceased alive on <u>December 6, 1956</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Walther H. Sonnenfeld</u> M.D.	
22. PHYSICIAN'S NAME (Type) Walther H. Sonnenfeld, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE SIGNED 12/7/56	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Connolly Esq. - M.D.</u>		25. ADDRESS ADDRESS	
26. DATE THEREOF Dec. 10-56		27. NAME OF CEMETERY OR CREMATORIAL Oak Lawn	
28. LOCATION (City, town, or county) Eastern Blvd., Balt. Md.		29. REC'D BY REGISTRAR, DATE REC'D 10/10/56	
30. REGISTRAR'S SIGNATURE <u>C. Harry Keys</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Cause of Death

Date of Death

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	114
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12321 CERTIFICATE OF DEATH

12300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3801-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 2000 Guilford Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Earl	Middle	Last Gill	4. DATE OF DEATH	Month 12	Day 14	Year 1956	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-6-12	9. AGE (in years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Weldon, N.C.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edward Gill		14. MOTHER'S MAIDEN NAME Maggie Silvin						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Earl Gill		Address 2000 Guilford Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure		DUE TO 002X		INTERVAL BETWEEN ONSET AND DEATH unknown				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Far advanced bilat-cavit. pulm. TBC		DUE TO (b)		17 years				
		DUE TO (c)		unknown				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore	20f. (City or town) Baltimore	(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from 12-11 , 19 56 , to 12-14 , 19 56 , that I last saw the deceased alive on 12-14 , 19 56 , and that death occurred at 3:40 PM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Baltimore, Maryland								
DATE SIGNED 12-14-56								
ACTUAL SIGNATURE T. F. Vestal								
M.D. Henryton, Md.								
PHYSICIAN'S NAME (Type) T. F. Vestal, M.D.		Henryton, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/56		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn		22d. LOCATION (City, town, or county) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Ms. Katie R. Williams		ADDRESS 322 N. Calvert Street		24a. REC'D BY REGISTRAR Albert R. Swankham		24b. REGISTRAR'S SIGNATURE Albert R. Swankham		
VS ATS (4) 15M 9/55				DATE 12/17/56				

CERTIFICATE OF DEATH

MURKIN

BUREAU X.

DEC 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 208 12-17-56 et

12322

CERTIFICATE OF DEATH

12301

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <i>CARROLL</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL WESTMINSTER</i>		c. LENGTH OF STAY IN 1b <i>77 YRS.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.D. 6</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural WESTMINSTER MD</i>	
3. NAME OF DECEASED (Type or print) <i>STATES L</i>		First <i>G</i>	Middle <i>I</i>
4. DATE OF DEATH <i>DEC. 5</i>	Month <i>DEC.</i>	Day <i>5</i>	Year <i>1956</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-17-1879</i>
9. AGE (In years last birthday) <i>85</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>JOSEPH M. GIST</i>	14. MOTHER'S MAIDEN NAME <i>NELLIE OGG GIST</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <i>NO</i>	16. SOCIAL SECURITY NO. <i>NAME</i>	17. INFORMANT <i>Central Hospital - 6 days</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c) Chronic nephritis - 2 years</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month <i>11</i>	Day <i>29</i>	Year <i>1956</i>
20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>Westminster Hospital</i>	20f. (City or town) <i>Westminster</i>	(County) <i>M.D.</i>
21. I certify that I attended the deceased from <i>11/29/56</i> to <i>12/5/56</i> , that I last saw the deceased alive on <i>12/5/56</i> , and that death occurred at <i>7A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Private Bare</i>	ADDRESS (Street, city or town, state) <i>Westminster Hospital</i>		
PHYSICIAN'S NAME (Type) <i>S. LUTHER BARE</i>	DATE SIGNED <i>12-9-56</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-7-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>MORGAN CHAPEL CEM</i>	22d. LOCATION (City, town, or county) <i>WOODBINE</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>David G. Bantard</i>	ADDRESS <i>Westminster</i>	24a. REC'D BY REGISTRAR DATE <i>12-9-56</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. H. Miller</i>

DEPARTMENT OF HOMELAND SECURITY
FEDERAL BUREAU OF INVESTIGATION
CERTIFICATE OF DEATH

BUREAU V. S.

DEC 12 1966

REGELIV E

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12302

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH

COUNTY CARROLL
 CITY (If outside corporate limits, write RURAL
OR
and give nearest town)
 TOWN FINNSBURG

MARYLAND

LENGTH OF STAY
(In this place)

25 yrs.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS**2. USUAL RESIDENCE (HOME) OF DECEASED**STATE MD.COUNTY CARROLLCITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN FINITSBURGSTREET
ADDRESS

(If rural give location)

**3. NAME OF
DECEASED**

(Type or Print)

(First) WILLIAM (Middle) MORDECIA(Last) GIST**4. DATE (Month) (Day) (Year)**

DEC. 28 1956

5. SEX M6. COLOR OR
RACE W7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) MARRIED

8. DATE OF BIRTH

SEPT. 11-1881

75

9. AGE last birthday

yrs.

IF UNDER 1 YEAR
Months DeyIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) RETIRED FARMER10b. KIND OF BUSINESS
OR INDUSTRY AGR

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT
COUNTRY? V-S-A

13. FATHER'S NAME

WM. M. GIST SR.

14. MOTHER'S MAIDEN NAME

KATE LITTLE15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) NO

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

-

17. INFORMANT & ADDRESS

LOMAL HUBBARD GIST MD FINNSBURGINTERVAL BETWEEN
ONSET AND DEATH

12 HRS.

422.1 IMMEDIATE CAUSE PULMONARY EDEMA

(A)

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)ARTERIOSCLEROTIC C. V. DISEASE

2-3 YEARS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. at work Not white
at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/27, 1956, to 12/28, 1956, that I last saw the deceased
alive on 12/27, 1956, and that death occurred at 2:00 AM, from the causes and on the date stated above.

SIGNATURE

Marta E. Strobel

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)
BURIAL

DATE THEREOF

12-30-56

NAME OF CEMETERY OR CREMATORIUM
METHODIST CEM.

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE JAN 3 1957Janet MillerDavid A. Hubbard Wilmington

REGISTRATION STATE INFORMATION TO HIGHLIGHT-ENTITLED 81

REGISTRATION OF DEATH

1960 FORM

REGISTRATION STATE INFORMATION TO HIGHLIGHT-ENTITLED 81

REGISTRATION STATE INFORMATION TO HIGHLIGHT-ENTITLED 81

REGISTRATION
STATE INFORMATION
TO HIGHLIGHT-ENTITLED 81

REGISTRATION
STATE INFORMATION
TO HIGHLIGHT-ENTITLED 81

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STATE INFORMATION
TO HIGHLIGHT-ENTITLED 81

REGISTRATION
STATE INFORMATION
TO HIGHLIGHT-ENTITLED 81

BUREAU V. S.

JAN 3 1960

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, one funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12324

CERTIFICATE OF DEATH

12303

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 3 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) Harriet		First Maynard	Middle Griffith
4. DATE OF DEATH Dec.	Month Dec.	Day 20	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-77
9. AGE (In years lost birthday) 19 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical work		10b. KIND OF BUSINESS OR INDUSTRY -Unk-	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lloyd C. Colliflower		14. MOTHER'S MAIDEN NAME Lucretia Ann Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 44-4-4444	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis with 450.0 DUE TO cardiac involvement Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause last.</u> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-13, 1955, to 12-20, 1956, that I last saw the deceased alive on 12-20, 1956, and that death occurred at 10:20 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrude Springfield		ADDRESS (Street, city or town, state) M.D. Springfield State Hospital Sykesville Md.	
PHYSICIAN'S NAME (Type) Gertrude Springfield		DATE SIGNED 12/21/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/24/56	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) Montgomery Co., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John C. Lumley, Jr. Harbor		ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DATE 12-24-56
			24b. REGISTRAR'S SIGNATURE C. Harry Wren

BUREAU V. S.

DEC 27 1956

REGEIYED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12325

CERTIFICATE OF DEATH

12304

Reg. Dist. No. 83

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Keymar		c. LENGTH OF STAY IN 1b 43 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural— Keymar Keymar		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Lawrence	Middle Henry	Last Hahn	4. DATE OF DEATH December 19	Month 19	Day Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1876		9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hahn				14. MOTHER'S MAIDEN NAME Alice Morningstar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-36-2573		17. INFORMANT Mrs. Lawrence Hahn, Keymar, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		DUE TO Right Sided Heart Failure				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Chronic myocarditis					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Glenelg	(County) Howard	(State) Maryland
21. I certify that I attended the deceased from <u>Dec 2</u> , 1956, to <u>Dec 19</u> , 1956, that I last saw the deceased alive on <u>Dec 19</u> , 1956, and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. <u>Glenelg</u> <u>Bridg</u> <u>Md</u>		DATE SIGNED <u>12-20-56</u>	
ACTUAL SIGNATURE <u>J. H. Legg</u>							
PHYSICIAN'S NAME (Type) <u>J. H. Legg</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/22/56	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Keysville Cemetery Paneytown, Maryland	22d. LOCATION (City, town, or county) Keysville, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				24a. REC'D BY REGISTRAR DATE DEC 26 1956	24b. REGISTRAR'S SIGNATURE <u>Robert Swett</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. **DOMESTIC-OUTSIDE-TRANSITATION STATE-MAILGRAM**

BUREAU A. S.

DEC 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12326

CERTIFICATE OF DEATH

Reg. Dist. No. 12305

74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15-54-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 11 Hamilton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carroll		First	Middle	Last	4. DATE OF DEATH HOLT	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> January 1, 1884	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Richard Holt		14. MOTHER'S MAIDEN NAME Rosella Mamyette		Address Springfield Hospital records				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH hours		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO Cerebral arteriosclerosis years		(c) DUE TO Generalized arteriosclerosis years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome with organic brain disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from November 28, 1956, to December 18, 1956, that I last saw the deceased alive on December 17, 1956, and that death occurred at 6:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 12/18/56						
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland						
22a. BURIAL OR CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 26, 1956		22c. NAME OF CEMETERY OR CREMATORI Rock Creek		22d. LOCATION (City, town, or county) Washington, D.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14 th St. N.W.		24a. REC'D BY REGISTRAR DEC 19 1956		24b. REGISTRAR'S SIGNATURE C. Harry Hays		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. JONATHAN'S PARK 1019 MTR 30 STAR 01415AM

BUREAU V.

1956 08 05

RECEIVED
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G209, 1/7/57 fcy CERTIFICATE OF DEATH

12306
Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be refused by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 yrs. 7 mos. 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) John Peter HONEK		d. STREET ADDRESS Unknown	
4. DATE OF DEATH December 25 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Poland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Springfield Hospital records.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
Years			
Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Schizophrenic reaction, paranoid type.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 7, 1953, 19 to December 25, 1956, that I last saw the deceased alive on December 25, 1956, and that death occurred at 11:48 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) M.D. Springfield Hospital Sykesville, Maryland	
DATE SIGNED 12/26/56			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) 12-29-56	
22b. DATE THEREOF 12-29-56		22c. NAME OF CEMETERY OR CREMATORIAL New Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 12-29-56	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE C. Harry Ulmer	

U. S. BUREAU

1557 3 NJ

REGGIE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12307

12328 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 19 days (10)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs, Md.		d. STREET ADDRESS 9504 Riley Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Ann	Last Horn	4. DATE OF DEATH 12	Month 8	Day 19	Year 56
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-76	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gebhard Long		14. MOTHER'S MAIDEN NAME Margaret Anne Hodgkins					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. unkn none		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)					
DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chron. brain syndr. assoc. with arteriosclerosis with psych. reactions						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield State Hospital	(County) (State)
21. I certify that I attended the deceased from alive on		10-30-1956, to 12-8-56, that I last saw the deceased 12-8-1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 12-8-56	
ACTUAL SIGNATURE Edmund Lusthaus	EDMUND LUSTHAUS		MD		Springfield State Hospital		
PHYSICIAN'S NAME (Type) Edmund Lusthaus			Sykesville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT	22b. DATE THEREOF 12/11/56	22c. NAME OF CEMETERY OR CREMATORIUM ABBEY MAUSOLEUM		22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Werner & Lumphrey	ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 12-11-56		24b. REGISTRAR'S SIGNATURE C. Harry Clever		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 4
DEC 17 1936 -
REGEL V. E.O.

DEC 17 1956 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12329

CERTIFICATE OF DEATH

12308
77

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>		c. LENGTH OF STAY IN 1b <i>44 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>301 N MAIN ST.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>	
3. NAME OF DECEASED (Type or print) <i>Lucinda</i>		d. STREET ADDRESS <i>301 N. MAIN ST.</i>	
4. DATE OF DEATH <i>December 17</i>		Month <i>December</i>	Day Year <i>1956</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JUNE 22, 1857</i>	
9. AGE (In years lost, birthday) <i>99</i>		10. IF UNDER 1 YEAR Months <i>0</i>	
11. IF UNDER 24 HRS. Days <i>0</i>		12. IF UNDER 24 HRS. Hours <i>0</i>	
13. FATHER'S NAME <i>LUTHER Martin</i>		14. MOTHER'S MAIDEN NAME <i>MARY TRACEY.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>DAISY FAIR</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>422.1</i> (b) <i>Arterio-sclerotic Cardi. (vascular disease)</i> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>(?)</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>—</i> 19 p. m. <i>—</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>	
(County) <i>—</i>		(State) <i>—</i>	
21. I certify that I attended the deceased from <i>March 15, 1945</i> to <i>Dec 17, 1956</i> , that I last saw the deceased alive on <i>Dec 17, 1956</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Joseph E. Bush</i>			
ADDRESS (Street, city or town, state) <i>Hampstead Maryland</i>			
DATE SIGNED <i>12-17-56</i>			
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Grace Mett</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 20 56</i>	
22d. LOCATION (City, town, or county) <i>Baltimore Md</i>		(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Clifton, Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>12/19/56</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Henry D. Reid</i>	

91-28047-188-HC 108-139 THE MELBOURNE AT 7:00AM 1991

BUREAU V.

DEC 26 1956

REGEL V ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12309

12330 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester Rural</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>near Melrose</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester Rural</i>			
d. STREET ADDRESS <i>near Melrose</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Bilia</i>	Middle <i>Kayser</i>	Last <i>December 28 1956</i>		
4. DATE OF DEATH	Month <i>Dec</i>	Day <i>28</i>	Year <i>1956</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 18 1877</i>		
9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Joseph Lippy</i>	14. MOTHER'S MAIDEN NAME <i>Caroline</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Howard M Kayser, Manchester Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Hypertension Cardio-Vascular Disease</i> (c) INTERVAL BETWEEN ONSET AND DEATH <i>Suddenly</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>				
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White Not white of week or work <i>—</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>Jan 6 1956</i> to <i>Dec 28 1956</i> that I last saw the deceased alive on <i>Dec 23 1956</i> , and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Hampstead Md</i> DATE SIGNED <i>12/28/56</i>					
ACTUAL SIGNATURE <i>Joseph E. Bush</i>	M.D.				
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>	HAMPSTEAD MD				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-31-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. David's</i>	22d. LOCATION (City, town, or county) <i>York Co Pa</i>	(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie & Tipton - Hampstead Md</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE <i>Dec 31-56</i>	24b. REGISTRAR'S SIGNATURE <i>Mrs. Mrs. Donner</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

BUREAU V. S

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12310

12306

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY CARROLL CO.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		b. COUNTY CARROLL CO.	
c. LENGTH OF STAY IN lb 65 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 LONGWELL, AVE.		d. STREET ADDRESS 44 LONGWELL, AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA MAE KIMMEEY		First	Middle
		Last	4. DATE OF DEATH DEC. 3
		Month	Day
		Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH MAY 11, 1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) CARROLL CO., MD.	
13. FATHER'S NAME JOHN WESLEY YINGLING		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT MISS RUTH A. KIMMEEY, WESTMINSTER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 24 hours	
(b) DUE TO arteria sclerosis		5 yrs?	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-2 , 19 56 , to 12-3 , 19 56 , that I last saw the deceased alive on 12-3 , 19 56 , and that death occurred at 4:30 M. from the causes and on the date stated above. ACTUAL SIGNATURE C. L. Billingslea PHYSICIAN'S NAME (Type) C. L. Billingslea		ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 12-4-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 6, '56	
22c. NAME OF CEMETERY OR CREMATORIUM WESTMINSTER CEM.		22d. LOCATION (City, town, or county) WESTMINSTER, MD. (State)	
22e. FUNERAL DIRECTOR'S SIGNATURE J. S. Mayers, Jr., Westminster, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE 12-5-56	
		24b. REGISTRAR'S SIGNATURE Harriet Miller	

CERTIFICATE OF DEATH

RECEIVED

RECEIVED

BUREAU V. S.

DEC 7 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12331 CERTIFICATE OF DEATH

12311

Reg. Dist. No.

82483

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine P. O.		c. LENGTH OF STAY IN 1b 6 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Day, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine P. O.			
3. NAME OF DECEASED (Type or print) First HENRY		d. STREET ADDRESS Day, Md.			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1887		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworking		10b. KIND OF BUSINESS OR INDUSTRY Casket Mfg.			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles W. Krich		14. MOTHER'S MAIDEN NAME Catherine Meyers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 212-18-5803 Mr. Walter Ruby Woodbine P. O., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 DEC 56 12 DEC 56			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955, 19, to Dec, 1952, that I last saw the deceased alive on 12 DEC, 1952, and that death occurred at 7 A M, from the causes and on the date stated above. ACTUAL SIGNATURE Howard E. Hale, M.D.				ADDRESS (Street, city or town, state) Jeffersville, Md. DATE SIGNED 12 Dec 52	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/56		22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven	
22d. LOCATION (City, town, or county) Baltimore, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. 715 Light St. Baltimore, Md.		ADDRESS DATE 11/10/56		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mrs. Robert Deny	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

FEDERAL BUREAU OF INVESTIGATION

DEC 14 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Route #1 Taneytown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>2 years</u> STATE <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Taneytown</u> STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>Russell</u> <u>Harrison</u> <u>Krug</u> (First) (Middle) (Last)		(Month) <u>December</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 11, 1887</u>
9. AGE last birthday <u>69</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>	11. KIND OF BUSINESS OR INDUSTRY <u>General farming</u>	12. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Rufus Krug</u>	14. MOTHER'S MAIDEN NAME <u>Pritilla Knipple</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>219-20-1316</u>		17. INFORMANT & ADDRESS <u>Mrs. Ernest Eyler, Taneytown, Maryland</u>
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>381X</u>		IMMEDIATE CAUSE (A) <u>Intracranial Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>(Cause undetermined)</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) <u>M.D.</u> (State) <u>49 Frederick St.</u>		21d. TIME OF INJURY (Month) <u>Dec. 4</u> (Day) <u>1956</u> (Year) <u>1956</u> (Hour) <u>8:45</u> M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 4, 1956</u> to <u>Dec. 14, 1956</u> , that I last saw the deceased alive on <u>Dec. 12, 1956</u> , and that death occurred at <u>8:45</u> p.m., from the causes and on the date stated above. SIGNATURE <u>R. S. McVaugh</u> DATE SIGNED <u>12/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/17/56</u>	NAME OF CEMETERY OR CREMATORIAL <u>Reformed Cemetery</u> LOCATION (City, town, or county) <u>Taneytown, Maryland</u>
24. REC'D BY REGISTRAR DATE <u>DEC 18 1956</u>		REGISTRAR'S SIGNATURE <u>H. H. Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Gross</u> ADDRESS <u>Merwyn C. Gross, Taneytown, Maryland</u>

WISCONSIN STATE BOARD OF HEALTH-PATHOLOGY

CERTIFICATE OF DEATH

DECEASED PERSON

NAME OF DECEASED PERSON

NAME OF DOCTOR

ADDRESS OF DECEASED PERSON

ADDRESS OF DOCTOR

NAME OF DECEASED PERSON

NAME OF DOCTOR

ADDRESS OF DECEASED PERSON

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ADDRESS OF DECEASED PERSON

ADDRESS OF DOCTOR

BUREAU U. S.

DEC 17 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

12313

12333

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Mr. Westminster			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Mr. Westminster, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) Westminster, Md. R.D.7			d. STREET ADDRESS Westminster, Md. R. D. 7		
3. NAME OF DECEASED (Type or print) First Middle Last Jacob Erven Leese			4. DATE OF DEATH Month Day Year 12/10/56 19		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/1882	9. AGE (In years lost, birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer			10b. KIND OF BUSINESS OR INDUSTRY Any where a days work could be had.	11. BIRTHPLACE (State or foreign country) York County, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Leese			14. MOTHER'S MAIDEN NAME Lamande Schafer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Jacob J. Leese Address Jacob J. Leese, R.D.7, Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH 1/12 Cerebral Hemorrhage Cardio Renal Vascular disease 47 yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 1957, to <u>Dec 10</u> , 1957, that I last saw the deceased alive on <u>Dec 8</u> , 1957, and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.			21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE <u>Chas. R. Foote</u>			ADDRESS (Street, city or town, state) M.D. <u>Westminster, Md.</u> DATE SIGNED <u>12/12/56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial (Burial) 12/13/56		22b. DATE THEREOF 12/13/56		22c. NAME OF CEMETERY OR CEMETORY St. Bartholomew Cemetery	
22d. LOCATION (City, town, or county) Mr. Hanover		22e. (State) Pennsylvania		22f. LOCATION (City, town, or county) York County	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>			24a. REC'D BY REGISTRAR DATE 12/12/56		
24b. REGISTRAR'S SIGNATURE <u>Hamet Miller</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y.

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be required by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12331

CERTIFICATE OF DEATH

12314
76

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD3 WESTMINSTER		c. LENGTH OF STAY IN lb 2 YRS.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD3 WESTMINSTER		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HERBERT LAMAR LEISTER		First HERBERT	Middle LAMAR				
4. DATE OF DEATH DEC 23	Month DEC	Day 23	Year 1956				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 7-1882				
9. AGE (In years lost birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECOMPTROLLER-GEAR+AXLE PLANT	11. BIRTHPLACE (State or foreign country) M.D.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ABRAHAM LEISTER	14. MOTHER'S MOTHER'S NAME CHARLOTTE PAYNE	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 877-03-5437				
17. INFORMANT VIOLET TONELLA LEISTER RD 3	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Hour a. p. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RD3 WESTMINSTER	20f. (City or town) BALTIMORE	(County) M.D.	(State) M.D.
21. I certify that I attended the deceased from alive on Dec 22 1956	21. I certify that I attended the deceased from alive on Dec 22 1956	21. I certify that I attended the deceased from alive on Dec 22 1956	21. I certify that I attended the deceased from alive on Dec 22 1956	21. I certify that I attended the deceased from alive on Dec 22 1956	21. I certify that I attended the deceased from alive on Dec 22 1956	21. I certify that I attended the deceased from alive on Dec 22 1956	21. I certify that I attended the deceased from alive on Dec 22 1956
ACTUAL SIGNATURE W.C. Leister	PHYSICIAN'S NAME (Type) W.M. Carl Jarnette	22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-27-56	22c. NAME OF CEMETERY OR CREMATORIUM WYRIDERS CEM.	22d. LOCATION (City, town, or county) WESTMINSTER	(State) M.D.	ADDRESS (Street, city or town, state) Westminster, 12-27-56
23. FUNERAL DIRECTOR'S SIGNATURE David G. Barkard Westminster, Md.	ADDRESS David G. Barkard Westminster, Md.	24a. REC'D BY REGISTRAR DATE 12-28-56	24b. REGISTRAR'S SIGNATURE Kamal Muller				

RECEIVED

MARYLAND STATE GOVERNMENT

BALTIMORE, MARYLAND

RECEIVED

DEC 31 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12315

12307

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH

o. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

27 Westminster

c. LENGTH OF STAY IN lb

34 yrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

43 Webster St

3. NAME OF DECEASED
(Type or print)First
EMMA

Middle

Last
LITTLE

4. DATE OF DEATH

Month
Dec. Day
14 Year
1956

5. SEX

f. 6. COLOR OR RACE

W.

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Sept 8 1880

9. AGE (In years last birthday)

76 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Housewife

—

12. CITIZEN OF WHAT COUNTRY?

Wilmington, Del. U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Henry Nagle ? Ryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. S. W. Little, Westminster, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

241X Myocardial degeneration 3 or 4 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO Severe bronchial asthma 40 yrs.

DUE TO (b)

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED While Not while at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 13, 1956, to Dec. 14, 1956, that I last saw the deceased alive on Dec. 13, 1956, and that death occurred at 7 A.M. from the causes and on the date stated above.

ADDRESS (Street, city, town, state)

DATE SIGNED

ACTUAL SIGNATURE

DR E. Reese WILKENS

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF Dec. 16-56

22c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cen.

22d. LOCATION (City, town, or county) Rural Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Rogers, Jr. Westminster, Md.

ADDRESS

24a. REC'D BY REGISTRAR DATE 12-15-56

24b. REGISTRAR'S SIGNATURE Hamilton Mullin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

WYOMING STATE DEPARTMENT OF HEALTH - CALIFORNIA

EC 17 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12335

CERTIFICATE OF DEATH

12316

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 2 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PULLEN NURSING HOME		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EMILIA	Middle FREDERICKA	Last MAHN	4. DATE OF DEATH 12 - 12 1956	Month 12	Day 12	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY, 23, 1875	9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN ?		14. MOTHER'S MAIDEN NAME WILLIAMENA MAHN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ***		17. INFORMANT JOHANNA L. CLATTERBUCK		Address GAITHER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO (c) epithelial carcinoma of stomach secondary						INTERVAL BETWEEN ONSET AND DEATH 5 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sykesville, Md.	(County) Howard Co.
21. I certify that I attended the deceased from September, 1956 , to December, 1956 , that I last saw the deceased alive on December 11, 1956 , and that death occurred at 4:00 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 12-12-56	
ACTUAL SIGNATURE Bertrand R. Gail.			M.D.				
PHYSICIAN'S NAME (Type) Bertrand R. Gail.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-15-56	22c. NAME OF CEMETERY OR CREMATORIUM ST. JOHNS CEMETERY		22d. LOCATION (City, town, or county) HOWARD CO.		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE C. T. Waltz	ADDRESS Wingfield, Md.	24a. REC'D BY REGISTRAR 12-17-1956		24b. REGISTRAR'S SIGNATURE C. Harry Keen			

2013 RELEASE UNDER E.O. 14176

DEC 17 1956

РЕГЕЛИВ ЕД

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12336

CERTIFICATE OF DEATH

12317

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
CARROLL MARYLAND		MARYLAND CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RURAL		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RURAL	
3. NAME OF DECEASED (Type or print) MATTIE		First	Middle
5. SEX FEMALE		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH OCT. 5, 1888		9. AGE (In years from last birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) FLOYD VIRGINIA
13. FATHER'S NAME DAVID WEEKS		14. MOTHER'S MAIDEN NAME MARY WEEKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT HUSBAND John A. MARSHALL Address Westminster
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral hemorrhage	
DUE TO (b)		Arterio-sclerotic C-V disease	
DUE TO (c)		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 28, 1956, to Dec 3, 1956, that I last saw the deceased alive on Dec 3 - 56, 1956, and that death occurred at 3:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE James J. Marsh PHYSICIAN'S NAME (Type) JAMES T. MARSH M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/56	22c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK
23. FUNERAL DIRECTOR'S SIGNATURE D. Hartzler & Sons, New Windsor, Md.		24a. REC'D BY REGISTRAR DATE 12-6-56	24b. REGISTRAR'S SIGNATURE Harriet Miller

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12318

12337

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD. 4 WESTMINSTER		c. LENGTH OF STAY IN 1b 47 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD. 4 WESTMINSTER	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle MYERS	Last MARTIN
4. DATE OF DEATH	Month DEC.	Day 30	Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 7, 1909
9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 15 YRS. MUSHROOM PLANT	10b. KIND OF BUSINESS OR INDUSTRY 13. FATHER'S NAME JACOB MARTIN	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
14. MOTHER'S MAIDEN NAME MARTHA MYERS	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or number) NO		
16. SOCIAL SECURITY NO. 213-09-9224		17. INFORMANT MRS. GRACE MARTIN WESTMINSTER, MD.	Address R.D. 4, SEVERAL HOUSES
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH several hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Probable Coronary Sclerosis			
(c) DUE TO Urticaria		1 da.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 30, 1956 , to Dec. 30, 1956 , that I last saw the deceased alive on Dec. 30, 1956 , and that death occurred at 9:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE VS. A15 (4) 15M 9/55		ADDRESS (Street, city or town, state) 12/31/56	
PHYSICIAN'S NAME (Type) XN. GLENN SPEICHER M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-2-1957	22c. NAME OF CEMETERY OR CREMATORIUM TRIDELIE CEMETERY WESTMINSTER, MD.
23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard Westminster, Md.		24a. ADDRESS 1-4-57	24b. REGISTRAR'S SIGNATURE Harold Miller

CERTIFICATE OF DEATH

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BUREAU V. S.

JAN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 209 1-1157 Ans

12319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 74

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		13 X - 2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Francis	Middle 	Last MARTIN	4. DATE OF DEATH December 26, 1956	Month December	Day 26	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (in years last birthday) 45 yr.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Springfield Hospital records.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending microscopic study Myocardial infarction 420.0 DUE TO hours								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of the coronary artery hours								
DUE TO (c) Arteriosclerotic heart disease years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
C.B.S. associated with alcoholism. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Do not know.						
20c. TIME OF INJURY Hour a. m. p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown Unknown		20f. (City or town) (County) Howard (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 12/26/56
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-56		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Burial at Height Cemetery, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12-29-56		24b. REGISTRAR'S SIGNATURE C. Harry Wier		

BUREAU V. S.

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12339

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12339 (12320)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>	
3. NAME OF DECEASED (Type or print) <i>William</i>		First <i>A.</i>	Middle <i>Mayer</i>
4. DATE OF DEATH Month <i>Dec.</i> Day <i>28</i> Year <i>1956</i>		5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>Jan. 23, 1890</i>		9. AGE (In years lost birthday) <i>66</i> yrs. <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John H. Mayer</i>		14. MOTHER'S MAIDEN NAME <i>Anna Nagengast</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>		16. SOCIAL SECURITY NO. <i>Yuk</i>	
17. INFORMANT <i>Mr. Butcher & Mayer - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		<i>Thrombosis of coronary artery</i> <i>1 hr -</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic cardiovascular disease</i>		<i>several yrs -</i>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>28 December 1956</i> to <i>Death 28 Dec 1956</i> , that I last saw the deceased alive on <i>28 December 1956</i> , and that death occurred at <i>2:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.H. Lawson Jr. M.D.</i>		ADDRESS (Street, city or town, state) <i>Liberty Road at Eldenberg - M.D.</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>W.H. Lawson Jr. M.D.</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>1-2-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Memorial</i>	
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Butcher & Height - Sykesville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>12-31-56</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>C. Harry Weber</i>	

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12321

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY	12340 Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	o. STATE Maryland		b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Sykesville		c. LENGTH OF STAY IN 1b 4 yrs. 8 mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 2910 Louise Ave., Zone 14	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lillian	Middle M.	Last Tucker	MILLER	4. DATE OF DEATH December 21, 1956	Month December	Day 21	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1878	9. AGE (In years 77 yrs.)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Walter Tucker	14. MOTHER'S MAIDEN NAME Lavinia Nallie							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT Springfield Hospital Records.	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH Years		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Fractured neck, right femur.</u>								
DUE TO <u>Senile psychosis, depressed, agitated type.</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured neck, right femur.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on ward floor.</u>							
20c. TIME OF INJURY Hour o. m. p. m. <u>Nov. 12 1956</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) <u>Sykesville</u>	(County) <u>Carroll</u>	(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>James T. Marsh</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>12/21/56</u>		
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/56</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Western Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tichner & Sons</u>	ADDRESS <u>Baltimore 17, Md.</u>	24a. REC'D BY REGISTRAR <u>DEC 26 1956</u>	24b. REGISTRAR'S SIGNATURE <u>John J. Tichner</u>					
VS. A15ME(5) 5M 9/55								

WISCONSIN STATE INSURANCE DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12322

12341

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. 4 Reese		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster	
3. NAME OF DECEASED (Type or print) First William Middle Richard Last Miller		d. STREET ADDRESS R. 4 Reese	
4. DATE OF DEATH December 29		Month Year 1956	Day
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 27, 1892	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME August Miller		14. MOTHER'S MAIDEN NAME Sarah Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-36-4248	
17. INFORMANT M. Stanley Miller		Address R 4 Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) — (X-ray & biops. studies made 12-156)		INTERVAL BETWEEN ONSET AND DEATH about 4 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29, 1956 to 12-29, 1956 that I last saw the deceased alive on 12-28, 1956, and that death occurred at 19 M. from the causes and on the date stated above. ACTUAL SIGNATURE C. L. Billingslea M.D. ADDRESS (Street, city or town, state) DATE SIGNED Westminster, Md. 12-29-56			
PHYSICIAN'S NAME (Type) C. L. Billingslea, M. D.		22d. LOCATION (City, town, or county) Sandymount, Maryland (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56	
22c. NAME OF CEMETERY OR CREMATORIAL Sandymount		24a. REC'D BY REGISTRAR DATE JAN 2 1957	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		24b. REGISTRAR'S SIGNATURE Harriet Miller	
ADDRESS Westminster, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the certificate in the funeral director's office. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12323

12342

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4yr, 7mo, 21dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 V 01-4	
3. NAME OF DECEASED (Type or print) First August Middle George Last MUNDT		4. DATE OF DEATH Month December Day 17, Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Frederick H. Mundt		12. CITIZEN OF WHAT COUNTRY? Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Springfield Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia; Senile psychosis, simple deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955, to December 17, 1956, that I last saw the deceased alive on December 16, 1956, and that death occurred at 5:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Agustin del Campo, M.D. DATE SIGNED 12/17/56			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Springfield State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/56	
22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.		22d. LOCATION (City, town, or county) Balto., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickerter & Sons - Baeto. 17, Md.		24a. REC'D BY REGISTRAR DATE 12/17/56	
		24b. REGISTRAR'S SIGNATURE Harry Star	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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RECEIVED

BUREAU V.

DEC 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12343

CERTIFICATE OF DEATH

12324

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>		b. COUNTY <u>CARROLL</u>	
c. LENGTH OF STAY IN 1b <u>11 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>45 CHARLES ST.</u>		d. STREET ADDRESS <u>45 CHARLES ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CARRIE</u>		First <u>BLANCHE</u>	Middle <u>MYERS</u>
4. DATE OF DEATH <u>DEC. 31 1956</u>		Month	Day
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH ?		9. AGE (In years lost birthday) <u>75</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MT. AIRY, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN MYERS</u>		14. MOTHER'S MAIDEN NAME <u>LUCY ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HELENA BRIGHTFUL, Westminister, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <u>Terminal & compensation</u> <u>Hypertension & cerebral artery</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>No</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>X</u> 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1215 Fernside</u>
20f. (City or town) <u>X</u>		(County) <u>X</u> (State) <u>X</u>	
21. I certify that I attended the deceased from <u>12-28, 1956</u> to <u>12-31, 1956</u> , that I last saw the deceased alive on <u>12-30, 1956</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>W. C. Stone</u> ADDRESS (Street, city or town, state) <u>1215 Fernside</u> DATE SIGNED PHYSICIAN'S NAME (Type) <u>W. C. STONE M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 2, 56</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Fernside Cem.</u>
22d. LOCATION (City, town, or county) <u>Rural, Westminster, Md.</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-1-57</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12341

CERTIFICATE OF DEATH

Reg. Dist. No.

1232576

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BD2 WESTMINSTER		c. LENGTH OF STAY IN 1b 48 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ETHEL NE MUMFORD MYERS		4. DATE OF DEATH DEC. 24 1956	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 96-1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MELCHIOR HARRIS	14. MOTHER'S MAIDEN NAME EDYAB.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-05-1333	17. INFORMANT CHARLES C. MYERS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Carcers of intestines, with extension to liver	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE E. Reese Wilkins		PHYSICIAN'S NAME (Type) E. Reese Wilkins	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-27-56	22c. NAME OF CEMETERY OR CREMATORIAL WESTMINSTER CEM.
22d. LOCATION (City, town, or county) WESTMINSTER MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE David W. Bankard Westminster, Md.		24a. REC'D BY REGISTRAR DATE 12-28-56	24b. REGISTRAR'S SIGNATURE Norman Milne

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BUREAU V. S

DEC 31 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12345

CERTIFICATE OF DEATH

12326

Reg. Dist. No. 80

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
CARROLL MARYLAND		MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR		c. LENGTH OF STAY IN lb YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HIGH STREET		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR	
3. NAME OF DECEASED (Type or print) C		First EDGAR	Middle NUSBAUM
4. DATE OF DEATH Dec.		Lost Month 4	Day Year 1956
5. SEX MALE		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH SEPT. 18, 1875		9. AGE (In years lost birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY RETAIL - OWN STORE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISAIAH NUSBAUM	
14. MOTHER'S MAIDEN NAME MARGARET NAILL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 213-16-1584		17. INFORMANT WIFE KITTY NUSBAUM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b) DUE TO c)		19. INTERVAL BETWEEN ONSET AND DEATH 10 mos. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 10, 1956 to Dec 3, 1957, that I last saw the deceased alive on Mar. 27, 1956, and that death occurred at 1:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) EUREESE Wilkens M.D. 15 Kemper, Westminster, MD DATE SIGNED 12/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 6-1956	22c. NAME OF CEMETERY OR CREMATORIAL WESTMINSTER
22d. LOCATION (City, town, or county) WESTMINSTER		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE D D HARTZLER & SONS		ADDRESS NEW WINDSOR MD	24a. REC'D BY REGISTRAR DATE Dec 3
			24b. REGISTRAR'S SIGNATURE Eusea S. Benedict

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please report carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

DEC 11 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12327

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 yrs. 9 mos. 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Grace		First Middle Beulah	Last OTTO
4. DATE OF DEATH December	Month 27	Day 19	Year 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. B. DATE OF BIRTH May 15, 1884		9. 9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Yank	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Severe coronary sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute cystopyelonephritis; fracture of right lower leg.</u> <u>Psychotic depressive reaction.</u>			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
Years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor of ward.	
20c. TIME OF INJURY Hour o. m. p. m. Nov. 21 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Sykesville	
(County) Carroll		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED 12/27/56	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-56	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Glenwood Park		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tom Cook, Inc.		24a. REC'D BY REGISTRAR DATE 12-27-56	
24b. REGISTRAR'S SIGNATURE C. Harry Weber		(State)	

MANHATTAN DISTRICT ATTORNEY'S OFFICE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 31 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12328

74

12347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 4 yrs. 11 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		d. STREET ADDRESS 914 "M" Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Annie	Middle ---	Last Pedrick	4. DATE OF DEATH 12-	Month 12-	Day 21-	Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 6-10-85	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Gebhart				14. MOTHER'S MAIDEN NAME Margaret Hoffmogel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. ---		17. INFORMANT Springfield State Hospital Hospital Records -- Sykesville, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> INTERVAL BETWEEN ONSET AND DEATH 1-hr. 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Cerebral arteriosclerosis</u> 10 yrs. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---							
20c. TIME OF INJURY Hour o. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		(County)	(State)
21. I certify that I attended the deceased from <u>3-24-52</u> , 19, to <u>12-21-</u> , 19 56, that I last saw the deceased alive on <u>12-21-</u> , 19 56, and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>M. N. Mastin</u> ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 12-21-56									
PHYSICIAN'S NAME (Type)		M. N. Mastin, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 24-56		22c. NAME OF CEMETERY OR CREMATORIUM OAKLAWN		22d. LOCATION (City, town, or county) EASTERN BLD, BALTO.			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Connally</u>		ADDRESS Essex - 2nd. D		24a. REC'D BY REGISTRAR DATE 26 1956		24b. REGISTRAR'S SIGNATURE <u>Harry Steers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANITOBA STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

1950

1950

BUREAU V. S.

DEC 27 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12348

CERTIFICATE OF DEATH

12329

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster, Rural</i>		b. COUNTY <i>Carroll</i>	
c. LENGTH OF STAY IN 1b <i>2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster, Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>EVA - KOLLER - PRESTON</i>		4. DATE OF DEATH <i>Dec 23 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 8-1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nurse</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James H Preston</i>		14. MOTHER'S MOTHER'S NAME <i>Mary Koller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-10-5637</i>	
17. INFORMANT <i>Mrs Lynn Grebe - 122 W Clement St</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Coronary occlusion 14 hrs</i>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>260x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>arteriosclerosis indefinite</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		DUE TO <i>arteriosclerosis indefinite</i>	
(b) <i>260x</i>		DUE TO <i>Diabetes 20 yrs</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>valvular heart disease</i>		19. WAS AUTOPSY PERFORMED? <i>NO</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Dec 23 1958</i>	
		(County) <i>Carroll</i>	
		(State) <i>Md</i>	
21. I certify that I attended the deceased from <i>Dec 22 1958</i> to <i>Dec 23 1958</i> alive on <i>Dec 22 1958</i> , and that death occurred at <i>6am</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Reedsville, MD</i>	
ACTUAL SIGNATURE <i>E. REESE N. KENS</i>		DATE SIGNED <i>12/26/58</i>	
PHYSICIAN'S NAME (Type) <i>E. REESE N. KENS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-26-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Manchester</i>		22d. LOCATION (City, town, or county) <i>Carroll Co Md</i>	
		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie E. Tipton Hanepstead Md</i>		ADDRESS	
		24a. REC'D BY REGISTRAR <i>Harriet Mullin</i>	
		DATE <i>12-26-58</i>	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 12 yr, 1 mo, 15 d		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 v o 1 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 9 East Fort Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Hoffman	Last REDDISH	4. DATE OF DEATH December 6 1956	Month December	Day 6	Year 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1877	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Hoffman				14. MOTHER'S MAIDEN NAME Katherine Weaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> INTERVAL BETWEEN ONSET AND DEATH days 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>904.7</u> (b) <u>Thrombosis right iliac vein</u> days DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of right femur Psychosis with convulsive disorder, epileptic deterioration 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient slipped and fell					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <u>James T. Marsh</u> DATE SIGNED <u>12/6/56</u>							
EXAMINER'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 12/10/56		22c. NAME OF CEMETERY OR CREMATORIAL Moreland Park		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Avenue				24a. REC'D BY REGISTRAR 12/6/1956		24b. REGISTRAR'S SIGNATURE <u>C. Harry Heers</u>	

BUREAU V. S.

DEC 10 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12350 CERTIFICATE OF DEATH

12331

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 2 yrs. 3 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 715 Montford Ave. - Baltimore, Md.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Catherine		First Catherine	Middle —	Last Roach	4. DATE OF DEATH 12-7-1956	Month 12	Day 7	Year 1956	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-1-1879	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Days —	12. IF UNDER 24 HRS. Hours —	13. IF UNDER 24 HRS. Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Margaret O'Neill							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital records - Springfield State Hosp.		Address —			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 2/2 hour					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Cardio-vascular condition		5 yrs.					
DUE TO —		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —
21. I certify that I attended the deceased from 9-21-1954 to 12-7-1956 that I last saw the deceased alive on 12-6-1956 , and that death occurred at 9:20 AM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Springfield State Hospital									
DATE SIGNED 12-7-56									
ACTUAL SIGNATURE M. N. Mastin, M.D.									
PHYSICIAN'S NAME (Type) M. N. Mastin, M.D.		Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-1956		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery		22d. LOCATION (City, town, or county) Edmondson Ave. Baltimore		(State) —	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc.		ADDRESS 1735 Harford Avenue		24a. REC'D BY REGISTRAR 12/10/56		24b. REGISTRAR'S SIGNATURE C. Harry Steen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

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DEC 11 1956

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TO HOSPITAL OR MEDICAL CENTER: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAC: After this certificate has been signed by the attending physician and completely filled in, it should be retained for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG209 1-4-57 et

CERTIFICATE OF DEATH

Reg. Dkt. No. 12333

12252

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 19	
3. NAME OF DECEASED (Type or print)		First James Middle Wenceslaus Last Slechta	4. DATE OF DEATH Month 12 - Day 22 - Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Communications Manager		10b. KIND OF BUSINESS OR INDUSTRY Western Union	11. BIRTHPLACE (State or foreign country) Maryland, Baltimore
13. FATHER'S NAME Joseph Slechta		14. MOTHER'S MAIDEN NAME Rose Chvala	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH months	
422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Myocarditis	
DUE TO (c)		Dermatomyositis	
three years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia reactions, paranoid type.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-27-1956 to 12-22-1956, that I last saw the deceased alive on 12-22-1956, and that death occurred at 7:30p.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Agustín del Campo M.D.		12-23-56	
PHYSICIAN'S NAME (Type) Agustín del Campo M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12/28/56	
22b. DATE THEREOF 12/28/56		22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cem.	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE C. SCHMIDT		ADDRESS 2601 E. 14TH ST	24a. REC'D BY REGISTRAR DATE DEC 28 1956
		24b. REGISTRAR'S SIGNATURE Cathary, Hause	

IF YOU ARE PLEASED TO TALK TO US, PLEASE CALL 1-800-333-2222.

BUREAU V. 3

DEC 28 1956 -

RECEIVED
DEC 30 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12353

CERTIFICATE OF DEATH

12334

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lykleville</i>		c. LENGTH OF STAY IN 1b <i>35 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lykleville</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Eliza</i>	Middle <i>Michael</i>	Last <i>SPENCER</i>
4. DATE OF DEATH	Month <i>DEC</i>	Day <i>29</i>	Year <i>1956</i>
5. SEX <i>Fr.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-27-1859</i>
9. AGE (In years last birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Henry C. Reich</i>	14. MOTHER'S MAIDEN NAME <i>Rachel Delashmitt</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Lindsay Spencer - Lykleville, Md.</i>	Address,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis generalized, cerebral</i> DUE TO (c) <i>Sclerosis,</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept</i> , 1956, to <i>DEC</i> , 1956, that I last saw the deceased alive on <i>29 DEC</i> , 1956, and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i>	ADDRESS (Street, city or town, state) <i>Lykleville, Md.</i> DATE SIGNED <i>29 Dec 56</i>		
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>	SYKESVILLE, MD.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-2-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Olivet</i>	22d. LOCATION (City, town, or county) <i>Frederick, Md.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard E. Hall - Lykleville, Md.</i>		24a. REC'D BY REGISTRAR <i>12-31-56</i>	24b. REGISTRAR'S SIGNATURE <i>C. Harry Weller</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's office. If this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
FBI - BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE				
JAN 3 1957				
BUREAU V. S.				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12335

12354

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARSHFIELD		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER	
d. STREET ADDRESS HOLLOW ROCK RD.		d. STREET ADDRESS HOLLOW ROCK RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALBERT	Middle DAVID	Last STEPHAN
4. DATE OF DEATH	Month DEC	Day 2	Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891
9. AGE (In years last birthday) 65	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. R.W.Y. FOREMAN W.M.D. M.D.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DAVID STEPHAN	14. MOTHER'S MAIDEN NAME MARY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 705-10-4885	17. INFORMANT MRS HAROLD PICKETT	Address 11 Hollow Rock Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis			
DUE TO (c) Chronic Cirrhosis Liver & Malnutrition			
INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
Several yes			
Several yes			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1 , 1956, to Dec 2 , 1956, that I last saw the deceased alive on Dec 2 , 1956, and that death occurred at 11:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Mr. GLENN SPEICHER M.D.		ADDRESS (Street, city or town, state) Westminster, Md	
PHYSICIAN'S NAME (Type) Mr. GLENN SPEICHER M.D.		DATE SIGNED 12/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC 5 56	22c. NAME OF CEMETERY OR CREMATORIAL LEISTER'S CEM	22d. LOCATION (City, town, or county) WESTMINSTER
23. FUNERAL DIRECTOR'S SIGNATURE H. BANKARD & SON WESTMINSTER MD		24a. REC'D BY REGISTRAR DATE 12-3-56	24b. REGISTRAR'S SIGNATURE DATE 14 am 11/11/56

CERTIFICATE OF DEATH

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DEC 7 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12355

CERTIFICATE OF DEATH

12336

Reg. Dist. No. 114

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 19yrs. 7mos. 27days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3016 Vineyard Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Margaret	Middle STEWART	Last	4. DATE OF DEATH	Month December	Day 12	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1907	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sam Stewart		14. MOTHER'S MAIDEN NAME Margaret -					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Springfield Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 171X DUE TO Carcinoma of the cervix of the uterus with metastases to the lungs. INTERVAL BETWEEN ONSET AND DEATH One yr. plus							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 002X		(b)		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General paresis; tuberculosis of lung.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from <u>July 1, 1950</u> , to <u>December 12, 1956</u> , that I last saw the deceased alive on <u>December 12, 1956</u> , and that death occurred at <u>8:45A M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Walther H. Sonnenfeldt, M.D. Springfield State Hospital DATE SIGNED 12/12/56							
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-56		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walther H. Sonnenfeldt, M.D.		ADDRESS Sykesville, Md.		24a. REC'D. BY REGISTRAR DATE 12-13-56		24b. REGISTRAR'S SIGNATURE O. Harry W. Lee	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

DEC 17 1956

РЕГЕЛИВ ЕД

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transcript.

VS 45C-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12337

CERTIFICATE OF DEATH

Reg. Dist. No.....

12356

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Carroll CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural-Taneytown		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Taneytown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)	
Female White		Flora L. Stuller	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female White		Married	Sept. 10, 1887
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		Own home	Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Amos L. Fowble		Alice Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Carcinoma, Head of Pancreas 4 yrs.	
157X IMMEDIATE CAUSE (A)		ANTECEDENT CAUSE(S) DUE TO	
DISEASES OR CONDITIONS, IF ANY, (B)		GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
July 52 = Am 10:30		Carcinoma, Head of Pancreas	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
M.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at A.M., from the causes and on the date stated above.			
SIGNATURE James J. Marsh		ADDRESS (Street, city, town, state) Limestone Rd	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/19/56	
24. REC'D BY REGISTRAR DATE DEC 19 1956		REGISTRAR'S SIGNATURE A. F. Fuss	
25. FUNERAL DIRECTOR'S SIGNATURE Mervyn C. Fuss		ADDRESS Uniontown, Carroll, Maryland	
Mervyn C. Fuss Taneytown, Maryland			

DEPARTMENT OF STATE - WASHINGTON, D. C.

CERTIFICATE OF DEATH

NO. 12, 1956

NAME OF DECEASED: JOHN BROWN

DEATH DATE:

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12357

CERTIFICATE OF DEATH

12338
94

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14		d. STREET ADDRESS 5611 Tramore Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First William		Middle TANKERSLEY		4. DATE OF DEATH December 3, 1956	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1865		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown			10b. KIND OF BUSINESS OR INDUSTRY WATCHMAN RETIRED 12 YRS.		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Hiram Tankersley				14. MOTHER'S MAIDEN NAME Biddy SHORES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 217 14 1294		17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 days DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Cerebral Arteriosclerosis years DUE TO (c) Generalized Arteriosclerosis years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 27, 1956, to December 3, 1956 , that I last saw the deceased alive on December 2, 1956 , and that death occurred at 7:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. Springfield State Hospital 12/3/56							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/6/56		22c. NAME OF CEMETERY OR CREMATORIUM MORELAND MEMORIAL CEM.		22d. LOCATION (City, town, or county) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MARYLAND				ADDRESS 12/6/56		24a. REC'D BY REGISTRAR C. Harry Keay	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED DECEMBER 5 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12358

CERTIFICATE OF DEATH

Reg. Dist. No. 12339

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b yrs. 3mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) Mary		First Elizabeth	Middle Trainor
4. DATE OF DEATH 12	Month 13	Day 19	Year 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-1870
9. AGE (In years lost birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 12	11. IF UNDER 24 HRS. Days 13	12. IF UNDER 24 HRS. Hours 19
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (State or foreign country) Baltimore City, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown - George Gonce		14. MOTHER'S MAIDEN NAME Unknown Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Hospital Records - Springfield State Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 1-hr.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized arteriosclerosis 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-18-1952 to 12-13-1956 that I last saw the deceased alive on 12-12-1956, and that death occurred at 10:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE M. N. Mastin M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/56	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.
22d. LOCATION (City, town, or county) Baltimore, Maryland (State)		ADDRESS (Street, city or town, state) Springfield State Hospital	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE 12-14-56	24b. REGISTRAR'S SIGNATURE O. Harry Klein

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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12359

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Sykesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Klee Mill Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle R	Last WAIZ
4. DATE OF DEATH	Month DEC	Day 22	Year 1956
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-17-1898
9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Cowan Transfer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael Walz		14. MOTHER'S MAIDEN NAME Blendia ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-28-7944	
17. INFORMANT		Address Ida G. Walz, Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420, 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO CARDIAC failure.		INTERVAL BETWEEN ONSET AND DEATH Nov 15 56 22 Dec 56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1956, to DEC 1956, that I last saw the deceased alive on 22 DEC 1956, and that death occurred at 8:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Howard E. Hall PHYSICIAN'S NAME (Type) Howard E. Hall			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-26-1956	
22c. NAME OF CEMETERY OR CREMATORIAL Evergreen Mem. Gardens		22d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DEC 27 1956		24b. REGISTRAR'S SIGNATURE C. Harry Keen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
DEC 27 1966

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12341

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3711 Thornapple St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Eugene	Middle William	Last WELLS
4. DATE OF DEATH	Month December	Day 11	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1869
9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer	10b. KIND OF BUSINESS OR INDUSTRY - Ymk	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edgar Wells	14. MOTHER'S MAIDEN NAME Marietta Buckingham		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. - 579-12-5203	17. INFORMANT Springfield Hospital records.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 422.1 (b) Generalized Arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 13, 1956, to Dec 11, 1956, that I last saw the deceased alive on Dec 11, 1956, and that death occurred at P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Agustín del Campo, M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Agustín del Campo, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/14/56	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	22d. LOCATION (City, town, or county) Suitland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey	ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DATE 12-18-56	24b. REGISTRAR'S SIGNATURE C. Harry Zeller

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12361 CERTIFICATE OF DEATH

12342

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 5yr, 10mo, 1dy		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John		d. STREET ADDRESS 6th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Minnie	Middle Gordon	Last WILLIAMS	4. DATE OF DEATH December	Month 28	Day 19	Year 56		
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 20, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Gordon			14. MOTHER'S MAIDEN NAME Ella Hansburg						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 7111		17. INFORMANT		Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome due to senile changes									INTERVAL BETWEEN ONSET AND DEATH hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>February 27, 1951</u> to <u>December 28, 1956</u> that I last saw the deceased alive on <u>December 27, 1956</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Walther H. Sonnenfeldt, M.D. Springfield State Hospital 12/28/56									
DATE SIGNED									
ACTUAL SIGNATURE Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland							
PHYSICIAN'S NAME (Type)		Walther H. Sonnenfeldt, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/30/56		22c. NAME OF CEMETERY OR CREMATORIUM Green Hill		22d. LOCATION (City, town, or county) Berwyn		(State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Ender		ADDRESS Berwyn, Va.		24a. REC'D BY REGISTRAR DATE 12-29-56		24b. REGISTRAR'S SIGNATURE C. Harry Allen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

129-1

BUREAU V. S.

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12343
 76

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X FINKSBURG.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 140				d. STREET ADDRESS Route 1				
3. NAME OF DECEASED (Type or print) HERMAN		First	Middle	Last	4. DATE OF DEATH Dec 20 1956			
5. SEX m		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-23-33		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trimmer		10b. KIND OF BUSINESS OR INDUSTRY Tree Trimming		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Clyde Yelton				14. MOTHER'S MAIDEN NAME Olamay Colbart				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-34-9835		17. INFORMANT Eugene Yelton		Address Reisterstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH min.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE SKULL -				DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)				DUE TO				
(c)				DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) automobile accident						
20c. TIME OF INJURY Month, Day, Year Hour 7 p.m. 12/20 1956		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 140		20f. (City or town) FINKSBURG (County) CARROLL (State) MD		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE James T. Marsh				DATE SIGNED 12/20/56				
EXAMINER'S NAME (Type) JAMES T. MARSH		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
REMOVAL (Specify) Burial		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22b. DATE THEREOF 12-23-56		22c. NAME OF CEMETERY OR CREMATORIAL Bakersville						
22d. LOCATION (City, town, or county) Bakersville, N. C.								
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR 12-22-56		
24b. REGISTRAR'S SIGNATURE James Miller								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.

DEC 27 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12344

Reg. Dist. No. 76

12353

1. PLACE OF DEATH a. COUNTY CARROL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R-WESTMINISTER		c. LENGTH OF STAY IN 1b 5 YEARS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTMINISTER RD #5		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINISTER R.	
3. NAME OF DECEASED (Type or print) CHARLES Enoch Zuck		First	Middle
4. DATE OF DEATH Month Dec Day 1 Year 1956		Last	Month
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3 1879
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY HANOV Heel	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME AMDROSC ZUCK		14. MOTHER'S MAIDEN NAME UNKNOWN GROFT.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Alvin C Zuck		Address Westminster RD #5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY Occlusion INTERVAL BETWEEN ONSET AND DEATH —			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE DUE TO YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		DATE SIGNED 12/1/56	
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/56	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery
22d. LOCATION (City, town, or county) Hanover, PA.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Negus Jr. Westminster, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE 12-2-56
			24b. REGISTRAR'S SIGNATURE Harriet Miller

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BUREAU V. S.

DEC 5 1956

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